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This study developed a set of policies and procedures to implement a same-day surgery clinic and developed a plan for marketing the clinic to the hospital staff. This study examined the financial impact of initiating a same day surgery clinic. The same-day surgery clinic offered many advantages. Medical Care Composite Unit credit began being received for procedures that were already being conducted. The benefit came from a change of some procedures from outpatient to inpatient status.

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A STUDY TO DEVELOP POLICIES AND PROCEDURES FOR IMPLEMENTING A SAME-DAY SURGERY CLINIC AT THE NEW US ARMY HOSPITAL AT FORT CARSON, COLORADO

A GRADUATE RESEARCH PROJECT

By

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of
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INTRODUCTION

Ambulatory surgery is defined as "surgery (generally of a minor nature) that does not require the patient to remain overnight in the hospital".[1] As can be expected, any mechanism which keeps patients out of the hospital will eventually grow in popularity. Such has been the case with ambulatory, i.e., same-day surgery, over the past ten years. Although many of these outpatient units are located in larger towns, they are beginning to appear in the less populated areas as well. Thus, "there's been a definite shift to frequent use of freestanding surgical facilities, hospital ambulatory facilities, and surgeon's own offices".[2]

Part of the reason for this changing pattern of health services utilization lies in the numerous advantages inherent in the use of an outpatient versus an inpatient facility. Not only does ambulatory surgery save patients' time away from work, but it also reduces the inpatient stay and subsequent charges for care.[3] From the health care institutions' viewpoint, the scheduling involved for outpatients allows for maximum utilization of personnel, resources, and inpatient beds for the more acutely ill. The lower utilization of inpatient beds negates the necessity of capital construction costs for the facility, and additionally reduces the need for medical record and clerical processing time. Thus the ambulatory surgery services continue to find favor from several market segments.

The Health Facilities Planning Agency (HFPA), the planning arm for the US Army Medical Department, is aware of this trend and is incorporating same-day surgery areas into new hospital construction projects. Consequently,

the new US Army Hospital at Fort Carson, Colorado will have the facilities to provide this service when it opens its doors in the summer of 1985. Unfortunately, the same-day surgery concept is not presently in operation at Fort Carson and must be developed if full utilization of the new facility is to occur.

Latest projections for the completion date of the hospital are that construction is running six months to one year ahead of schedule. Occupancy, therefore, may be as early as May of 1985. Staffing, equipping, and operating the same-day surgery service, then, must be of vital concern now. Furthermore, because of the extensive lead time involved both in ordering equipment and in requesting additional manpower, these two tasks could not be postponed until completion of this research project. As a result these requirements have already been accomplished by present personnel. The operating procedures for a same-day surgery clinic, however, do not exist. What is needed, therefore, is a complete set of procedures for implementing and operating the same-day surgery clinic in the new hospital at Fort Carson, Colorado.

Another need which must also be addressed if the same-day surgery concept is to be successful is getting the support of the hospital staff. At the present time, unfamiliarity with the concept is causing some resistance among the staff, i.e., a feeling that same-day surgery is not feasible for this facility. With these sentiments prevailing, the new service is doomed to failure. A plan, therefore, needs to be developed to market same-day surgery as a positive trend in improving health care delivery.

With the preceding thoughts in mind this researcher formulated a project to develop not only the policies and procedures for a same-day surgery operation, but also to develop a marketing plan to gain staff support. The

parameters and methodology under which the research project was conducted and the results of the research effort will be presented in the remainder of this report.

Statement of the Research Problem

The problem is to develop a set of policies and procedures which can be used to implement a same-day surgery clinic at the new US Army hospital at Fort Carson, Colorado, and to develop a plan for marketing the same-day surgery concept to the hospital staff.

Objectives

1. To conduct a literature review to determine types of procedures currently being done on a same-day surgery basis.
2. To collect policies and procedures from other health care facilities performing same-day surgery.
3. To conduct interviews with personnel involved in same-day surgery to ascertain problems or suggestions to consider in implementing a same-day surgery program.
4. To review current operations and to determine surgical procedures qualifying for same-day surgery at this facility.
5. To develop patient flow patterns for individuals using the same-day surgery service.
6. To develop policies and procedures for the following areas:
   a. Admission procedures;
   b. Selection criteria for patients for the Same-Day Surgery Clinic;
   c. Pre-operative preparation of the patient by the physician;
   d. Patient Administration Division pre-admission requirements;
   e. Handling of narcotics for the clinic;
   f. Anesthesia services, to include pre-medication policy;
   g. Discharge procedures.

7. To determine the impact in Medical Care Composite Units (MCCUs) of implementing same-day surgery given current workload.
8. To develop a plan for marketing same-day surgery to the hospital staff.

Criteria

1. Policies and procedures must be consistent with standards established by the Joint Commission on Accreditation of Hospitals and by the American College of Surgeons.
2. Administrative guidelines must conform to present Patient Administration Division regulations to insure appropriate MCCU credits and recording of diagnoses.

Assumptions

1. Necessary staffing and equipment will be provided.
2. The allotted space in the new hospital for the Same-Day Surgery Clinic will not change.
3. The clinic will not be used as an overflow for normal inpatient surgery.

Limitations

In reviewing surgical procedures in the operating room, data will be gathered from a single two month period.

RESEARCH METHODOLOGY

In order to develop a set of policies and procedures which can be used to implement a same-day surgery clinic at the new US Army hospital at Fort Carson, Colorado, and to develop a plan for marketing the same-day surgery concept to the hospital staff, an eight-phase analysis will be done.

Phase 1 - Review of the Literature

Journal articles and available information publications released within the last three years will be reviewed to determine trends in ambulatory surgery and the types of procedures being considered for one day surgery. In addition, this information will be used to help identify specific problem areas or procedures which should be addressed when initiating a same-day surgery operation.

Phase 2 - Information Gathering

Policies and procedures for same-day surgery clinics will be requested from facilities in Health Services Command which are currently operating these services. In addition, an attempt will be made to obtain procedural guides from hospitals in the Colorado Springs, Colorado area which are offering same-day surgery. This information will be used as a framework in determining which administrative procedures should be addressed when operating a same-day surgery clinic.

Phase 3 - Interviews

Personal contact with hospital personnel in the Colorado Springs area who are involved in ambulatory surgery will be made in order to ascertain problems or suggestions to consider in implementing same-day surgery. In addition, input from personnel at the US Army Community Hospital at Fort Carson will be solicited and incorporated into the procedural guides whenever possible.

Phase 4 - Review of Current Operations

Existing policies for inpatient admission and discharge procedures will be reviewed. In addition, a profile of potential same-day surgery procedures based on 1-2 day admissions at the US Army Community Hospital at Fort Carson, Colorado over the past two years will be requested from the Patient Administration Systems and Biostatistics Activity (PASBA). This data will be combined with information gathered in the preceding phases and will be used to determine suggested surgical procedures for the Same-Day Surgery Clinic.

Phase 5 - Review of Blueprints and Health Facility Planning Documents

The blueprints for the Same-Day Surgery Clinic at the new hospital will be reviewed to determine space allocation and physical layout. This information will be used to develop patient flow patterns for those individuals using same-day surgery services. In addition, available planning and programming documents from the Health Facilities Planning Office will be reviewed to clarify the proposed concept of same-day surgery for the new hospital. This information, in turn, will be used as a basis for developing policies and procedures for the clinic.

Phase 6 - Development of Policies and Procedures

At this point all of the preceding information from phases one to five will be integrated and restructured into suggested policy and procedural guidelines for the operation of the Same-Day Surgery Clinic in the new US Army hospital at Fort Carson, Colorado.

Phase 7 - Review of Workload Data

An analysis of surgical procedures performed in the operating room during a two month period which could have qualified for same-day surgery will be performed. This analysis will involve calculating the total Medical Care Composite Units (MCCUs) generated by these procedures being done as inpatients under the present system and comparing this total to the MCCU workload which would have occurred if these procedures had been done as same-day surgeries with only one admission day per procedure being used in calculating MCCUs. Those services using the operating room which could have performed same-day surgery will be identified. The log books from the outpatient clinics of these services will then be reviewed to determine which cases during this same two month period could have qualified for same-day surgery. A comparison of MCCUs generated by performing outpatient surgery versus same-day surgery with inpatient credit will be made. Using all of the preceding data, a comparison will be developed which shows the impact of same-day surgery on MCCUs. The loss in MCCUs which would have occurred if inpatient surgery were done as same-day surgery will be compared to the loss of MCCUs occurring during the same period because same-day surgery was not being done in the outpatient clinics.

Phase 8 - Marketing Plan

Using the previously developed concepts and analyses, a plan for marketing the same-day surgery program to the staff at the US Army Community Hospital, Fort Carson, Colorado, will be developed.

FOOTNOTES

[1]I. Donald Snook, Hospitals: What They Are and How They Work (Rockville, MD: Aspen Systems Corporation, 1981) p. 43.

[2]John H. Lavin, "Same-Day Surgery: Why Everyone is Learning to Love It", Medical Economics (June 7, 1982) p. 113.

[3]Snook, p. 44.

DISCUSSION

Review of the Literature

Although day surgery has been performed on minor cases for many years, the concept of intermediate day surgery did not really surface in this country until 1966 when hospital attached day units were opened in Los Angeles and Washington, D.C.[1] Gradually other units began to appear. The real impetus to same-day surgery, however, began in 1970 with the opening of the "Surgicenter" in Phoenix, Arizona. Since that time over a half million procedures have been performed in these centers without fatality.[2]

Surprisingly enough, however, a listing of suggested procedures for same-day or ambulatory surgery does not appear to have been published until 1976 when Thomas R. O'Donovan, Ph.D., presented a master listing of common operative procedures in ambulatory surgery in his book Ambulatory Surgical Centers: Development and Management. In this listing were 280 suggested procedures.[3] Since that time other groups have published their recommendations. Among these groups were the National Capitol Medical Foundation, Inc., a Washington, D.C. professional standards review organization. In 1979 this group released a list of 51 surgical procedures which had to be performed in an outpatient setting to qualify for Medicare or Medicaid reimbursement.[4] This list has since been increased to 56. Then in 1982 the U.S. Department of Health and Human Services, with input from the American College of Surgeons and the American College of Obstetricians and Gynecologists, released a list of 96 procedures eligible for 100 percent reimbursement under Medicare Part B.[5] Another group, Blue Shield of California, has issued a list of 700 procedures which it suggests can be done on an

outpatient basis.[6] As the popularity of ambulatory surgery increases not only with patients, but also with commercial insurers who see the advantages of not admitting patients to the hospital, the list of suggested procedures will undoubtedly increase.

Based on the literature review the Department of Health and Human Services' listing appears to be the most widely accepted proposal. This listing, therefore, was used as a starting point in evaluating potentially acceptable procedures for the Fort Carson Hospital. (See Appendix A for a summary of HHS suggested procedures.)

Information Gathering

Although ambulatory surgery is becoming fairly common in the civilian sector, this is still a relatively young concept for the US Army Medical Department, and only a handful of medical facilities have implemented same-day surgery to any degree. The number of hospitals considering this option, however, appears to be slowly increasing. The main impetus for this interest seems to be an attempt to increase workload, a key factor in determining staffing requirements and operating budgets for military hospitals.

Rather than to start developing procedures totally from scratch, an attempt was made to obtain copies of ambulatory surgery guidelines from facilities currently operating an active service. The staff of Walter Reed Army Medical Center, Madigan Army Medical Center, Fitzsimons Army Medical Center, Darnell Army Community Hospital, and George Washington University Hospital in Washington, D.C., willingly responded to a request for copies of their operating procedures. Although guidelines from local civilian hospitals were unavailable for photocopying, the highlights of two programs were physically reviewed while this researcher visited Penrose Hospitals

in Colorado Springs, Colorado, and Denver Health and Hospitals in Denver, Colorado.

Review of these programs revealed that approximately 100 procedures were being considered in the military as acceptable for same-day surgery. In fact the listings for the military hospitals were identical with the exception of one or two procedures. (See Appendix B for sample listing.) At George Washington University Hospital in Washington, D.C., on the other hand, the 56 procedures identified by the National Capitol Medical Foundation were being used as a basis for determining same-day surgery candidates. In the local civilian hospitals, however, determination on types of procedures appropriate for ambulatory surgery was made by the individual physician. As a result compiling a comprehensive list of procedures currently being performed was virtually impossible.

Interviews

The civilian hospitals were, however, very informative on how their ambulatory surgery services, or short-stay as they are called at Penrose Hospitals, are run. Interviews with Ms. Sharon Lee of Penrose Hospitals and Ms. Bobbie Klaus of Denver Health and Hospitals revealed that both facilities are operating a hospital-based facility. In addition the ambulatory surgery service shares both operating rooms and recovery room assets with inpatient services. In many respects this is an advantageous use of resources. In fact, in a 1980 American Hospital Association survey approximately 87 percent of responding hospitals (non-federal) reported that they operated a same-day surgery service and used existing inpatient resources.[7]

This practice does on occasion, however, result in outpatients being "bumped" from the operating schedule since inpatients and emergencies

usually have priority. Their recommendation, therefore, was to have at least one operating room and staff devoted full-time to ambulatory surgery. Of course the number of operating rooms required for same-day surgery will ultimately depend upon patient population, medical attitudes toward same-day surgery, and the rate of patient throughput.[8]

One additional point which was emphasized during both interviews was the relationship between the referring clinic and the inpatient services. At both facilities the clinics where patients are initially seen and referred for same-day surgery are also the areas responsible for obtaining required laboratory, radiology, and administrative reports. Thus the same-day surgery services function more as a processing unit and do not have the difficulty of separating inpatient charges from outpatient.

Another indepth interview which proved to be very productive was with Lieutenant Colonel Lawrence W. Moss, the nursing methods analyst at Fitzsimons Army Medical Center in Denver, Colorado. Because of the unique workload accounting mechanism which exists in the military, patients for same-day surgery are usually admitted the morning of surgery and discharged the same afternoon. In this manner the health care facility receives about 37 times the weighted workload value towards funding and staffing as it would if patients were not admitted for the day.

Although patients are administratively admitted to either an adult or a pediatric ward the patient may never set foot on that unit. The problem from an administrative standpoint, then, becomes one of omission, i.e., inpatient units may fail to annotate same-day surgery admissions and discharges on their ward census sheet. Furthermore, because the census sheet tallies with the number of patients physically present on the ward when the log is closed, the omission of same-day surgery patients can be easily

overlooked. This information must definitely be kept in mind if any modifications to the same-day surgery operation occur in the future.

Review of Current Operations

In reviewing hospital regulations and standard operating procedures this researcher soon discovered that a tentative plan for outpatient surgery was drafted in 1980. Unfortunately, very few hospital personnel were familiar with the provisions of this regulation. This regulation, MEDDAC Regulation 40-46-1, states that in addition to the administrative admission of patients to a ward and the completion of an Abbreviated Clinical Record (SF 539), all ancillary studies will be done not more than seven days prior to surgery. Ancillary studies include chest x-ray if general or regional anesthesia will be given, anesthesia evaluation for general or regional anesthesia, surgical consent form, CBC, differential, urinalysis, electrocardiogram for patients over 40 receiving general or regional anesthesia, and serology for patients over 14 years of age. The regulation governing preparation of patients for operative procedures, however, allows a 30 day window for chest x-rays.

When comparing these requirements to the policies from other military facilities, this hospital's guidelines are more stringent. The 1984 Joint Commission on Accreditation of Hospitals' (JCAH) standards, however, state that "when surgical services are provided in an ambulatory care setting, the policies and procedures shall be consistent with those applicable to inpatient surgery, anesthesia, and postoperative recovery".[9] These standards, therefore, need to be incorporated into the new policies and procedures for the Fort Carson same-day surgery service.

In evaluating the clinical forms to be used one must also note that the Abbreviated Clinical Record (SF 539) can only be used for patients receiving general anesthesia if they are American Society of Anesthesiologists (ASA) Physical Status Classification, Class I, and will be hospitalized no more than 72 hours. ASA Class I patients are those who have no organic, physiological, or psychological disturbances and who have a localized pathological process which is not conducive to systemic disturbance if the operation is performed.[10] In evaluating the most appropriate clinical records consideration must, therefore, be given to offering the use of the SF 539 in selected cases, of only allowing ASA Class I patients to undergo same-day surgery, or of using a more involved clinical record for all cases. Based on an evaluation of potential cases for same-day surgery the use of the SF 539 for all cases except general anesthesia candidates who have mild systemic disturbances would probably best meet the needs of this institution.

In coming to this conclusion the information presented by the Patient Administration Systems and Biostatistics Activity (PASBA) in San Antonio, Texas was very helpful. To assist this facility in determining which of the most frequently performed surgical procedures requiring only one or two days of admission should be considered potential same-day surgery candidates, PASBA provided a three year analysis of short-stay surgical admissions with only one surgical procedure coded on the medical record. Their analysis indicated that between 800 to 900 procedures each year are being performed here which required the overnight stay of a patient when, perhaps, these procedures could have been done on a same-day basis.

PASBA further stated that these procedures comprised approximately 14 percent of the total procedures performed for Fort Carson. PASBA's analysis also revealed that approximately 4 percent of the total operating bed days

for Fort Carson would be available for other use if this workload were shifted to a same-day surgery program. This shift would make more beds available for the acutely ill or for patients requiring surgery which could not be handled by a same-day surgery operation.

Once a listing of procedures requiring one to two day admission during calendar years 1981, 1982, and 1983 was prepared, PASBA went on to further analyze Fort Carson workload. The top 50 surgeries with one and two day admissions were then extracted from the initial listing. If one takes a closer look at these top 50 surgeries one sees that they account for approximately 90 percent of all short-stay surgical procedures. (See Appendix C.) Furthermore, almost 75 percent of the top 50 procedures involved only about 20 operation codes. (See Appendix D.)

The 176 operation codes involved in the initial analysis were then categorized by medical specialty. PASBA subsequently calculated the percentages of total surgeries at Fort Carson performed by those specialties during calendar years 1981, 1982, and 1983. (See Appendix E for summary of this analysis.)

Using the preceding information this researcher compared procedures currently being done at Fort Carson which are potential same-day surgery candidates with the lists previously collected from other facilities. Fort Carson's list of potential candidates is consistent with other military facilities which provide same-day surgery. With this task completed the next phase of the research methodology was ready to begin.

Review of Blueprints and Health Facility Planning Documents

Review of available information on the proposed same-day surgery clinic at Fort Carson reveals that the clinic is intended to be a separately defined area. Although the operating rooms used by outpatient surgery are connected to the bank of six inpatient operating rooms, the remainder of the same-day surgery clinic has its own complement of necessary support areas such as reception and waiting rooms, locker rooms for patients, preparation and holding areas, post-operative recovery, and utility and storage spaces. This proximity could be useful in the future, however, because the main recovery rooms and operating rooms would be available as backup if staffing or equipment problems occurred.

Using the preceding information a patient activity flow diagram can be developed which outlines the concept of same-day surgery as projected for the new hospital. Once the patient is admitted the following process would occur:

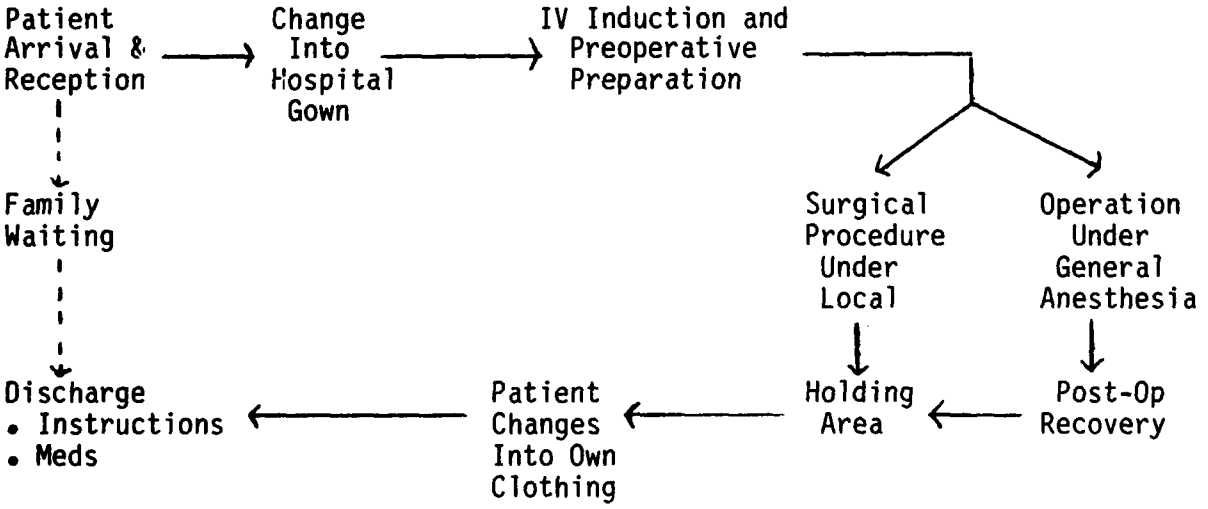


Figure 1. Patient Activity Flow Diagram.

A visual representation of this traffic flow using a blueprint-like schematic has been inclosed at Appendix F.

Development of Policies and Procedures

Using information gathered through literature review, collection of policies and procedures from other facilities, interviews, review of current operations, and review of Health Facility Planning Agency documents, basic guidelines for operating the Same-Day Surgery Clinic at the new hospital were developed.

Not only were suggested surgical procedures considered appropriate for same-day surgery outlined, but also basic guidelines were developed for seven other clinic procedures including admissions, selection criteria for patients for the Same-Day Surgery Clinic, pre-operative preparation of the patient by the physicians, Patient Administration Division pre-admission requirements, handling of narcotics for the clinic, anesthesia services to include pre-medication policy, and discharges. These policies and procedures are included as Appendixes G through N.

Although many more procedures could have been developed, these areas appeared to be key components. Many of the journal articles alluded to or discussed various aspects of these policies or procedures, especially when same-day surgery management was the key issue. For this reason only a handful of procedures appeared critical for development at this time.

Review of Workload Data

After careful consideration this researcher realized that an effective marketing plan for same-day surgery at this facility had to be based to a large part on concrete, factual information about the impact of implementing

this program given present workload. Based on information provided by PASBA and other military facilities the adoption of a same-day surgery operation has been shown to increase accountable workload by 10-15 percent. If a similar impact could be shown at this facility, the development of a marketing plan would be much easier. Consequently, a closer look at Fort Carson surgical activity appeared to be in order.

To assess the impact of same-day surgery on workload accounting at this facility an analysis of surgical procedures done on both an inpatient and outpatient basis was performed. For purposes of this study the period 1 February 1984 to 31 March 1984 was used as a data base. Thus the fluctuations caused by the Christmas holiday period were minimized and a more representative picture of surgical workload was hopefully obtained.

In the first part of the workload analysis the surgery log books from the operating room were reviewed. Those surgical procedures which have been identified as potential same-day surgery candidates were extracted from these logs. Approximately 70 cases being done each month in the operating room on a regular inpatient basis could, conceivably, qualify for same-day surgery. By shifting these cases to a same-day surgery program, additional time would be available in the main operating suite for more complicated surgeries.

Shifting these surgical cases from the main operating rooms, however, would impact on weighted workload values. Just what this impact would be required further analysis. Consequently medical records' data were obtained on the 136 potential same-day surgery cases to determine the total number of occupied bed days. The total MCCUs for each hospitalization were then calculated and then the totals added. The results of these calculations revealed that routine surgical admission and handling of these cases

generated over 2,000 MCCUs. (See Appendix O.) Interestingly enough, a brief review of admission and discharge data revealed that almost two dozen of these cases had passes or pre-weekend admissions for Monday surgeries which added approximately 50 MCCUs to the two month total. Also, many of the procedures which generated 20 to 30 MCCUs per patient involved active duty soldiers who were unable to be discharged to duty in as short a time span as the non-active duty patients. Thus a certain amount of "cushioning" occurs which helps increase actual workload reported.

In reviewing admission and discharge data another point became evident, i.e., that 73 or more than half of the 136 cases identified as potential same-day surgery candidates involved only one or two bed days. One can't help but wonder, then, if an overnight stay in the hospital was really warranted. What then would be the impact on MCCUs if all of these 136 cases were shifted to a same-day surgery program; if patients were still admitted; and if they were discharged the same day? The MCCUs generated for these 136 cases in this event would be 1,496 compared to the 2,064 when routine hospitalization occurred. Thus for the period February to March 1984 the effect of moving all eligible cases to a same-day surgery operation with no replacement of cases to the main operating room would be a net loss of 568 MCCUs.

The next part of the workload analysis involved identification of potential same-day surgery cases which were being done in outpatient clinics. In some instances physicians were performing these procedures in their clinics because sufficient operating time was unavailable in the operating suite. Several physicians admitted that they would prefer to do these cases in an operating room environment but settled for doing them in the office so patients would not have to wait excessively long for elective

procedures. In terms of workload value clinic procedures are weighted at 0.3 MCCUs compared to 11 MCCUs for a same-day surgery admission and discharge. Thus a same-day surgery credit would be better for MCCUs than an outpatient credit.

With these thoughts in mind this researcher reviewed the clinic records from the surgical as well as medical services for the two month period February-March 1984. Over 500 procedures were performed in the clinics which might have qualified for same-day surgery. In terms of MCCUs only slightly over 170 MCCUs were generated by counting these patients as outpatients. On the other hand, if these patients had been admitted for same-day surgery approximately 6,000 MCCUs could have been generated. (See Appendix P.)

Using the preceding data, then, one can see that a tremendous amount of workload is not being captured in a manner which could significantly increase workload accounting. If this two month period is in any way reflective of the remainder of the year thousands of MCCUs are being lost. One must realize, however, that all of this workload could not be captured in a same-day surgery operation. If, as this survey shows, a patient population exists with sufficient surgical potential to almost double monthly weighted workload data, one could assume that at least 10 percent to 15 percent of that could be reasonably channeled into a same-day surgery operation. In this manner, present personnel and budgetary needs could at least be justified.

Furthermore, one can see that incorporating clinic surgery procedures into a same-day surgery operation could more than offset the decrease in MCCUs if surgery procedures were at the same time moved from the main operating room areas. Because of the potential for increasing accountable workload, same-day surgery should definitely be considered for this hospital.

And, too, this concept should be seriously considered for implementation in the present facility if operating room scheduling can be arranged.

Development of a Marketing Plan

In developing a marketing plan for the ambulatory surgery concept in the civilian sector economic incentives play a vital role. Increased consumer emphasis on cost containment as well as changes in third-party reimbursement mechanisms have been instrumental in shifting health care delivery away from the inpatient setting. The physician, however, still plays a key role, and the major thrust of the marketing plan is to entice the physician into caring for his patients on a "same-day" basis. For this to occur the physician must be convinced of the economic incentives to himself and to his patients of adopting such a treatment plan. Recent changes in third-party reimbursement mechanisms have helped to clarify these incentives. Today's concerns about cost containment dictate that economic incentives remain a driving force in health care delivery, and that facilities which provide the highest quality of care at the lowest possible price will survive. Same-day surgery offers this option.

In the military environment, however, these economic incentives play a much lesser role. Personnel and funding requirements are based on historical data and a hospital is penalized if it shifts inpatient workload to an outpatient accounting center. To remain viable under present accounting mechanisms the major emphasis must be on admitting patients. The advantage of same-day surgery, however, can still be realized since patients are prescheduled and do not require overnight hospitalization. Thus the inpatient reporting requirements are satisfied, while the patient benefits by having his surgical procedure done on an "outpatient type" basis.

Although ambulatory surgery, or same-day surgery as it is also called, has been shown to have a significant impact on military health care facilities workload accounting, the concept is not widely accepted at this facility. Only a very few health care providers have worked with same-day surgery and there is a certain amount of bias or reluctance to initiate such a program. This is the main reason why a marketing plan needs to be developed, i.e., to gain hospital staff support for a same-day surgery operation.

Based on the two month study conducted at Fort Carson, sufficient workload potential is available from the clinics to drastically increase MCCUs. This is a key issue in that MCCUs must be maintained in order to justify personnel and budget requirements for opening the new hospital. Concerns about maintaining MCCUs have recently surfaced. During this fiscal year MCCUs at this facility have dropped dramatically. As a result major funding cuts of about $500,000 have been experienced by this hospital. If this decreasing workload trend is allowed to continue, this MEDDAC could very soon have difficulty in justifying its existence - must less personnel or financial requirements for a new facility.

One of the key objections to same-day surgery at this hospital appears to be reluctance to handle additional administrative requirements engendered by admitting patients to the hospital for the day. Health care providers see the laboratory studies and clinical documentation as burdens they would rather not tackle. And too, the thought of subjecting patients to a surcharge payment for procedures which have been "acceptable" as clinic surgery meets with some resistance. These concerns, of course, need to be addressed in the marketing plan.

Perhaps the one feature of same-day surgery which is able to offset these preceding objections is the ability to add significantly to the

hospital's accounting of MCCUs. The thirty-fold increase in MCCUs generated by a same-day surgery admission versus an outpatient clinic visit provides greater weighted workload for the physician's time. In fact, the physician receives as much credit for one surgical admission as he does for one whole day of clinic visits. And too, if medical records requirements are kept to a minimum as outlined in the procedures developed in this paper, the final result in terms of documentation is much less than that required to satisfactorily complete 30 plus outpatient records, the equivalent for workload accounting purposes.

For these reasons same-day surgery should be considered and promoted as a viable option for recapturing lost workload. The success or failure of the same-day surgery concept, however, will depend almost entirely on the attitudes of current staff, many of whom will be working in the new facility. Gaining their support, therefore, must be the focus of any marketing plan for this hospital. With these thoughts in mind the marketing plan outlined in Appendix Q was developed.

FOOTNOTES

[1]Paul Jarrett, "Sameday Progression", Nursing Mirror (March 10, 1982), p. 32.

[2]George L. Hoffmann, "Quality Control in Ambulatory Surgery", Bulletin of the American College of Surgeons, Vol. 66, No. 11 (November 1981) p. 6.

[3]Thomas R. O'Donovan, Ambulatory Surgical Centers: Development and Management (Germantown, Md.: Aspen Systems Corporation), pp. 203-207.

[4]"Ambulatory Surgery: When and What Procedures", Bulletin of the American College of Surgeons, Vol. 67, No. 11 (November 1982), p. 21.

[5]Health Care Financing Administration, "Medicare Program; List of Covered Surgical Procedures for Certain Ambulatory Surgical Services", Federal Register, Vol. 47, No. 151 (August 5, 1982), pp. 34099-34101.

[6]"Ambulatory Surgery: When and What Procedures", p. 21.

[7]Linda A. Burns and Mindy S. Ferber, "Ambulatory Surgery in the United States: Development and Prospects", The Journal of Ambulatory Care Management, (August 1981), p.7.

[8]James M. B. Burn, "Facility Design for Outpatient Surgery and Anesthesia", International Anesthesiology Clinics, Vol. 20, No. 1 (Spring 1982), p. 136.

[9]Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals, 1984, (Chicago: JCAH), 1983, p. 64.

[10]Bernard V. Wetchler, "The Role of Anesthesia in Outpatient Surgery", Today's OR Nurse, Vol. 4, No. 7 (September 1982), p. 20.

CONCLUSION

Same-day surgery programs in the United States are becoming increasingly more popular each year. The fact that they are located in most metropolitan areas and in many rural areas is evidence of this growth. Furthermore, in an era of cost consciousness same-day surgery offers economic incentives to health care facilities, health care providers, and health care consumers.

Although same-day surgery is an emerging concept for military hospitals, this practice is slowly gaining in popularity. Unlike the civilian sector, however, which considers same-day surgery as strictly an outpatient procedure, the military community must treat these patients on a limited inpatient basis for accounting purposes so they do not jeopardize their financial viability. From the patients' perspective this inpatient accounting will result in the payment of a minimal surcharge and may be an objection which needs to be addressed in the marketing plan developed for the military community. Increased patient satisfaction with having elective intermediate cases done in the more controlled environment of an operating room, however, may more than offset any hesitancy involved with the payment of surcharges.

At the Fort Carson hospital the major impact of same-day surgery would be felt in increasing MCCUs by pulling in intermediate care cases which are presently being done in outpatient clinics for the sake of expediency. Based on the two month analysis of workload in both inpatient and outpatient areas for the period 1 February - 31 March 1984, untapped workload in the outpatient clinics should be channeled into a same-day surgery program. The resultant increase in MCCUs would more than offset any inconvenience

experienced by health care providers in having additional administrative requirements necessitated by the inpatient handling of patients versus an outpatient. In essence health care providers would receive as much weighted credit for handling a same-day surgery patient as they would for a whole day of outpatient clinic visits. Even if as few as 20 patients a month were done on a same-day surgery basis the resultant 220 MCCUs would be a vast improvement over the six MCCUs the hospital would receive by handling these patients as strictly outpatients.

Of course, if only 20 cases a month were projected a separate same-day surgery staff would not be feasible. Based on projections by other facilities, however, the handling of six to eight patients a day or about 175 to 200 a month makes full time same-day surgery services feasible. Based on current workload these figures should not be difficult to obtain. Same-day surgery, then, becomes increasingly important as a means to regenerate dropping workload figures and to provide a quality alternative in health care delivery. The key to success, however, is a committed staff. Therefore a dynamic marketing plan which emphasizes the advantages both to patients and to health care providers must be actively developed and pursued. Once this task is accomplished the benefits to the hospital in terms of workload accounting and increased MCCUs can be realized.

APPENDIX A

HEALTH AND HUMAN SERVICES' LIST OF COVERED PROCEDURES

Auditory System

- Mastoidectomy, simple (transmastoid antrotomy)
- Myringoplasty
- Myringotomy (including aspiration and/or eustachian tube inflation)
- Stapedectomy
- Tympanoplasty (without mastoidectomy)

Cardiovascular System

- Temporal Artery, Ligation or biopsy
- Varicose Vein Ligation

Digestive System

- Branchial Arch Appendage Excision
- Colostomy Revision (simple)
- Esophagoscopy
- Fistulectomy
- Gastroscopy
- Hemorrhoidectomy
- Herniorrhaphy
- Liver Biopsy, percutaneous
- Peritoneoscopy (mini-laparatomy)
- Rectal Dilation
- Tongue Biopsy
- Vermilionectomy (Lip peel)
- Wedge Resection of Lip

Endocrine System

- Thyroglossal Duct Cyst Removal

Eye and Ocular Adnexa System

- Canthoplasty
- Cataract extraction
- Chalazion excision
- Discission lens (needling of lens)
- Ectropion/Entropion repair
- Enucleation, with and without implant
- Eye Muscle Operation (extraocular muscles, strabismus procedure)

Eye and Ocular Adnexa System (Cont'd)

- Foreign Body Removal
- Iridectomy
- Lacrimal duct probing or reconstruction
- Pterygium (excision or transposition)
- Tarsorrhaphy

Female Genital System

- Colpotomy, with exploration
- Culdoscopy (Culdocentesis)
- Dilation and curettage, diagnostic and/or therapeutic (nonobstetric)
- Examination under Anesthesia (pelvic)
- Hysterosalpingogram
- Laparoscopy
- Perineoplasty
- Vaginal Stenosis Release (Dilation of Vagina under Anesthesia)
- Vaginal tumor (cyst) excision
- Vulva (labia) biopsy

Hemic and Lymphatic System

- Cervical Node (lymph node) biopsy

Integumentary System

- Benign lesion, excision (lipoma)
- Breast biopsy (incision, excision uni-or-bilateral)
- Fingernail, toenail removal
- Gynecomastia excision, uni-and-bilateral
- Malignant lesion, excision (Basal Cell, Melanoma)
- Mandible cyst excision, simple
- Pilonidal cyst excision, simple, extensive
- Skin graft

Male Genital System

- Hydrocele excision
- Orchiectomy
- Prostate Biopsy
- Spermatocele excision
- Varicocele repair

Musculoskeletal System

- Arthrodesis
- Arthroplasty
- Arthroscopy
- Boutonniere repair
- Bunionectomy
- Bursectomy
- Capsulectomy/capsulotomy (metacarpophalangeal and interphalangeal)
- Closed Reduction of Nasal Fracture
- Fasciectomy/Fasciotomy
- Ganglionectomy (wrist)
- Hammertoe Repair
- Ligament Repair
- Neurectomy
- Neuroma excision (Morton's and cutaneous and digital nerves)
- Ostectomy metatarsal (metatarsal head excision)
- Osteotomy
- Phalangectomy (amputation, fingers and toes)
- Sequestrectomy
- Synevectomy
- Tendon Repair with graft, implant or transfer
- Tendon Repair without graft, implant or transfer
- Tendon Sheath Release (De Quervains)
- Tenotomy, hands, fingers, ankle, feet and toes
- Trigger Finger Release (tendon sheath incision for)
- Zygoma (Zygomatic arch) reduction

Nervous System

- Neurolysis (including carpal tunnel decompression
- Ulnar Nerve Repair
- Ulnar Nerve Transfer

Respiratory System

- Antral Window (puncture) (Sinusotomy)
- Bronchoscopy
- Ethmoidectomy
- Excision turbinate
- Laryngoscopy
- Nasal Polypectomy
- Septal Reconstruction
- Submucous Resection (turbinate and nasal septum)

Urinary System

- Cystourethroscopy
- Transurethral Resection of Bladder Tumor (Cystourethroscopy w/operative procedure)
- Urethral Dilation

Adapted from Federal Register listing, 5 August 1982.

APPENDIX B

PROCEDURES BEING CONSIDERED FOR SAME-DAY SURGERY IN ARMY MEDICAL FACILITIES

General Surgery

1. Hernia repair (adult and pediatrics)
2. Excisional biopsies
3. Gastroscopy (pediatric)
4. Superficial and integumentary lesions
5. Sigmoidoscopy (pediatric)
6. Orchiopexy
7. Frenulectomy
8. Anal and rectal biopsies
9. Node biopsies
10. Examination under anesthesia
11. Breast biopsy (2 stage procedure)
12. Breast biopsy (needle localization)
13. Rectal polypectomy
14. Excision sebaceous cyst
15. Drainage of simple hematoma
16. Arterial puncture on children
17. Esophagoscopy
18. Gastroscopy
19. Fistulotomy, subcutaneous
20. Fistulectomy
21. Hemorrhoidectomy, simple ligature
22. Aspirational biopsies
23. Pilonidal cyst

Genitourinary

1. Circumcision
2. Orchiopexy
3. Vasectomy
4. Vasovasectomies

Neurosurgery

1. Carpal tunnel release
2. Skull biopsies
3. Excision Morton's neuroma
4. Ulnar nerve transposition

Obstetrics and Gynecology

1. Elective sterilization
2. Diagnostic minilaparotomies
3. D&C
4. EUA
5. Removal of IUD
6. Diagnostic laparoscopies
7. Biopsy of perineum
8. Hymenectomy
9. Vaginal dilatation
10. Hysteroscopy

Ophthalmology

1. Strabismus surgery
2. EUA
3. Lacrimal duct probing
4. Cyclocryotherapy
5. Retinal cryopexy
6. Photocoagulation
7. Minor lid procedures
8. Blepharoplasty
9. Chalazion removal
10. Ptosis procedures
11. Pterygium removal
12. Cataract removal

Oral Surgery

1. Complicated exodontia (adult and pediatric)
2. Surgical removal of odontogenic and nonodontogenic lesions
3. Closed reduction of facial fractures

Orthopaedics

1. Closed reduction of simple fractures
2. Percutaneous pin fixation of fractures
3. Carpal tunnel release
4. Extensor tendon release
5. Tenosynovectomy, finger
6. Muscle biopsies
7. Shoulder, hip and knee manipulation
8. Cast change
9. Pin and wire removal
10. Removal foreign body in muscle, simple
11. Bunionectomy
12. Synovial biopsy
13. Diagnostic arthroscopy
14. Fasciotomy, palmar for DePuytrene's contracture
15. Ganglion excision
16. Tenotomy
17. Excision Morton's neuroma
18. Arthroscopic meniscectomy
19. Digital neurorraphy

Otolaryngology

1. Myringotomy (with or without insertion of PE tubes)
2. Removal of PE tubes
3. Septorhinoplasties
4. Nasal polypectomies
5. Maxillary antrostomies and antral windows
6. Closed reduction and fixation of nasal fractures
7. Small scar revisions of head and neck

Otolaryngology (Continued)

8. Diagnostic and therapeutic endoscopies
9. Type I tympanoplasties
10. Closed reduction of zygomatic arch (towel clip technique)
11. Frenotomy
12. Excision aural polyp
13. Adenoidectomy
14. Tonsillectomy
15. Biopsy of tongue

Plastic

1. Augmentation mammoplasty
2. Rhinoplasty
3. Minor scar revisions
4. Suture removal on children
5. Minor procedures on children requiring general anesthesia
6. Otoplasty
7. Cheiloplasty
8. Dermabrasion
9. Blepharoplasty

Thoracic

1. Rigid bronchoscopy
2. Rigid esophagoscopy
3. Esophageal dilation (primarily in children)
4. Removal of sternal wire or other appliances in ASA Class I and II
5. Debridement of chest wall sites not requiring hospitalization

APPENDIX C

SUMMARY OF PASBA ANALYSIS

a. Number of surgical procedures with one or two day admissions (Potential Day Surgery Procedures)*

1. CY 1981 - 816
2. CY 1982 - 950
3. CY 1983 - 843

b. Total of top 50 potential day surgery procedures

1. CY 1981 - 747
2. CY 1982 - 836
3. CY 1983 - 740

c. Percent of total procedures comprised by top 50

1. CY 1981 - 91%
2. CY 1982 - 88%
3. CY 1983 - 88%

*Does not include sterilization consisting of destruction or interruption of the fallopian tubes or vas deferens as single diagnosis.

Sterilization Procedures:
1. CY 1981 - 153
2. CY 1982 - 179
3. CY 1983 - 219

APPENDIX D

OPERATION CODES AND TITLES MOST FREQUENTLY FOUND IN LISTING OF TOP 50 POTENTIAL DAY SURGERY PROCEDURES

OP CODE	TITLE (ICPM)
5690	D and C of uterus
1679	Other specified endoscopy
5200	Myringotomy
5664	Other destruction or occlusion of fallopian tubes
5640	Circumcision
1694	Laparoscopy
5102	Advancement, recession ocular muscle
5217	Repair and plastic operations on nose
5101	Excision of ocular muscle, tendon with recession, advancement
5281	Tonsillectomy
1641	Colonoscopy
5530	Repair of inguino-femoral hernia
5884	Local excision, destruction, skin, subcutaneous tissue
3251	Intravenous urography
5231	Surgical removal of tooth
5043	Freeing adhesions, decompress nerve
1450	Biopsy of colon by endoscopy
1501	Surgical biopsy of breast
5860	Local excision of lesion of breast
3440	Computerized axial tomography of head

APPENDIX E

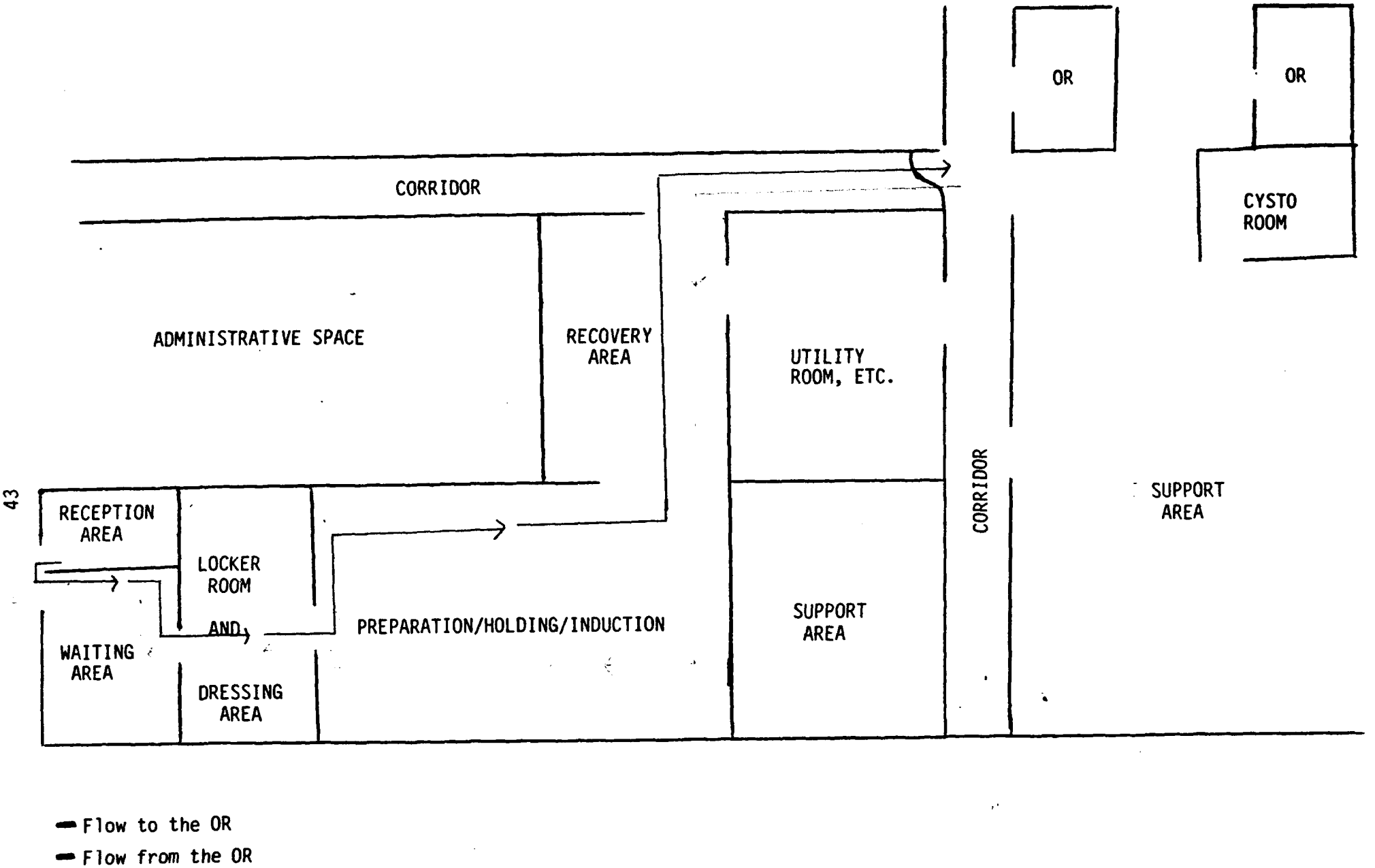
ANALYSIS OF SURGICAL PROCEDURES BY SPECIALTY

Breakdown, by medical specialty, of the percentage of total surgeries being done at Fort Carson with 1-2 day dispositions (Potential Day Surgery Procedures) for calendar years 1981, 1982, and 1983:

	Percentage of Total Surgeries		
Specialty	1981	1982	1983
Otolaryngology	2	3	1
Plastic Surgery	1	1	.2
Oral Surgery	2	2	1
Orthopedics	7	6	5
Genitourinary	7	9	10
Thoracic	1	1	1
Obstetrics & Gynecology	4	4	4
Ophthalmology	2	1	1
General Surgery	7	8	6
Neurosurgery	.5	1	.5

APPENDIX F

PATIENT TRAFFIC FLOW THROUGH SAME-DAY SURGERY CLINIC


OR
OR
CYSTO ROOM
CORRIDOR
ADMINISTRATIVE SPACE
RECOVERY AREA
UTILITY ROOM, ETC.
CORRIDOR
SUPPORT AREA
RECEPTION AREA
LOCKER ROOM
AND
PREPARATION/HOLDING/INDUCTION
SUPPORT AREA
WAITING AREA
DRESSING AREA
Flow to the OR
Flow from the OR

APPENDIX G

SUGGESTED PROCEDURES FOR THE SAME-DAY SURGERY CLINIC

A. The 1984 Accreditation Manual for Hospitals by JCAH requires policies for the types of elective procedures that may be performed in hospital sponsored ambulatory care services.

B. The following is a list of surgical procedures considered suitable for same-day surgery. Inclusion in this list does not require this procedure to be performed only on a same-day basis. Conversely, exclusion from this list does not imply that the procedure is unacceptable. Appropriate procedures for same-day surgery should be added to this list after approval by the Chief, Department of Surgery.

Auditory System

Excision aural polyps
Myringoplasty
Myringotomy (with or without insertion of PE tubes)
Type I tympanoplasties

Cardiovascular System

Ligation and stripping of varicose veins

Digestive System

Anal and rectal biopsies/polypectomy
Endoscopy
Esophagoscopy/esophageal dilation
Fistulectomy
Fistulotomy, subcutaneous
Frenotomy
Frenulectomy
Gastroscopy
Hemorrhoidectomy, simple ligature
Hernia repair (adult and pediatric)
Liver biopsy, percutaneous
Peritoneoscopy (mini-laparotomy)
Rectal dilation
Tongue biopsy
Wedge resection of lip

Eye and Ocular Adnexa System

Blepharoplasty
Cataract removal
Chalazion removal
Cyclocryotherapy
Discission lens (needling of lens)
Ectropion/extropian repair
EUA
Foreign body removal
Iridectomy
Iridotomy
Lacrimal duct probing or reconstruction

Eye and Ocular Adnexa System (Continued)

Minor lid procedure
Pterygium removal
Ptosis procedures
Retinal cryopexy
Strabismus surgery or other eye muscle operations

Female Genital System

Biopsy of perineum
Culdoscopy/culdocentesis
Diagnostic minilaparotomies
D&C
Elective sterilization
Examination under anesthesia
Hymenectomy
Hysterosalpingogram
Hysteroscopy
Laparoscopy
Perineoplasty
Removal of IUD
Vaginal dilatation
Vaginal cyst excision
Vulva biopsy

Hemic and Lymphatic System

Cervical node/lymph node biopsy

Integumentary System

Aspirational biopsies
Augmentation mammoplasty
Benign lesion/lipoma excision
Breast biopsy (needle localization)
Breast biopsy (2 stage procedure)
Cheiloplasty
Dermabrasion
Drainage of simple hematoma
Excisional biopsies
Excision sebaceous cyst
Fingernail, toenail removal
Malignant lesion, excision (basal cell, melanoma)
Mandible cyst excision, simple
Minor scar revision
Pilonidal cyst excision

Male Genital System

Circumcision
Hydrocele excision
Orchiectomy

Male Genital System (Continued)

- Orchiopexy
- Prostate biopsy
- Spermatocele excision
- Varicocele repair
- Vasectomy
- Vasovasectomies

Musculoskeletal System

- Arthroscopic menisectomy
- Arthroscopy
- Bunionectomy
- Cast change
- Closed reduction of nasal fractures
- Closed reduction of simple fractures
- Extensor tendon release
- Fasciectomy/fasciotomy
- Ganglionectomy
- Hammertoe repair
- Muscle biopsies
- Neuroma excision (Morton's and cutaneous and digital nerves)
- Ostectomy metatarsal (metatarsal head excision)
- Percutaneous pin fixation of fractures
- Pin and wire removal
- Removal foreign body in muscle, simple
- Shoulder, hip and knee manipulation
- Synovial biopsy
- Tenosynovectomy, finger
- Tenotomy
- Zygoma reduction, closed

Nervous System

- Carpal tunnel release
- Ulnar nerve transposition

Respiratory System

- Antral window
- Bronchoscopy
- Laryngoscopy
- Maxillary antrostomies
- Nasal polypectomy
- Septal reconstruction

Urinary System

- Cystourethroscopy
- Intravenous urography
- Urethral dilation

Other - Dental Procedures

Alveoloplasty with extraction
Biopsy
Maxillary sinusotomy
Removal of exostosis
Tooth removal, complicated
Tooth removal, impacted

C. Surgical Procedures Not Considered Suitable for the Same-Day Surgery Clinic:

1. Any surgery in which an unrelated procedure is being done simultaneously which itself requires hospitalization.

2. Any surgery in which another surgical procedure could follow the initial procedure, e.g., a one stage breast biopsy, followed by a mastectomy.

3. Any procedure requiring more than a four hour stay in the recovery room.

4. Any surgical procedure which requires major intervention in the abdomen or thorax.

5. Emergency surgery (unless the selection criteria are met and an exception is made).

APPENDIX H

ADMISSION GUIDELINES FOR THE SAME-DAY SURGERY CLINIC (SDSC)

All patients who are scheduled for surgery in the SDSC will be preadmitted to the hospital. After the patient has seen his/her physician and the requirements outlined in "Preoperative Preparation of the Patient by the Requesting Surgeon" have been completed, the patient is to report to the SDSC. The patient should have in his/her possession the following:

1) Abbreviated Medical Record (SF 539)

2) Doctors Order Sheet (DA Form 4256)

3) Operation Request and Worksheet (DA Form 4107)

4) Request for Administration of Anesthesia and for Performance of Operations and Other Procedures (SF 522)

5) The Anesthesia Clinical Record (SF 517)

6) Admission and Coding Information (DA Form 2985)

The patient will then take the DA Form 2985 to the admissions office to be pre-admitted. Immediately following the patient will return to SDSC with an addressograph plate. All required laboratory, x-ray, EKG forms, etc. will be stamped and completed by clinic personnel.

Once the patient has provided the SDSC with an address, place of employment, and home and work phone number should the need arise for him to be contacted, the patient will be given:

1) Preoperative instructions and a written pre-operative instruction sheet;

2) An appointment date and time to be seen by anesthesia if general or regional anesthesia is to be given;

3) An appointment date and the time and place where the patient is to report for surgery;

4) Instructions on where to go to have the laboratory tests completed; and

5) Instructions that if a responsible adult does not accompany him/her on the day of surgery, the surgery will not be done.

On the day that surgery is to be performed the patient will report to the admissions office to pick up an identification bracelet and to verify his admission. This is to be accomplished immediately prior to the patient's reporting to the SDSC.

APPENDIX I

SELECTION CRITERIA FOR PATIENTS FOR THE SAME-DAY SURGERY CLINIC

SELECTION OF PATIENTS: The decision to bring a patient in for same-day surgery is made by the attending physician. A number of factors should be considered in making this choice.

1) SIMPLICITY OF THE PROCEDURE: The operation to be performed must be able to be completed in less than an hour. Usually the procedures are of short duration, i.e., 15 to 20 minutes.

2) INCIDENCE OF POSTOPERATIVE COMPLICATIONS: Serious complications should be highly unlikely. There should be no anticipation that an overnight stay will be required. Recovery should be expected to be of short duration, i.e., of less than two hours with no anticipated anesthesia or operative complications.

3) GENERAL GOOD HEALTH OF THE PATIENT: Except for the condition to be treated the patient should be otherwise healthy or have a well controlled medical condition. Only American Society of Anesthesiologists Class I and II patients will be considered appropriate. ASA Class I and II for purposes of anesthesia are as follows:

CLASS I: The patient has no organic, physiological or psychiatric disturbance. A localized pathological process for which the operation is to be performed exists and is not expected to develop into a systemic disturbance, e.g., inguinal hernia.

CLASS II. The patient has a mild-to-moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes, e.g., diet controlled diabetes or essential hypertension.

4) RELIABILITY OF THE PATIENT: Patients must be capable of performing preoperative and postoperative care as outlined by the physician. Appropriate response to doctor's orders must be predictable.

5) PSYCHOLOGICAL ACCEPTANCE BY THE PATIENT: Patients should feel comfortable having the procedure done in the SDSC and should not appear emotionally overcharged or highly nervous at the prospect of same-day surgery. Patients should be aware that if unforeseen complications arise overnight hospitalization might be required. Patients should also be willing to accept same-day surgery in lieu of traditional hospitalization and be willing to pay any associated inpatient charges.

6) AGE AND SITUATION OF THE PATIENT: The adequacy of the home environment must be carefully considered to assure proper postoperative outcomes. Careful consideration should be given to individuals who may not have anyone at home following their surgery.

7) COOPERATION BY THE SURGEON: Since the surgeon selects patients for same-day surgery he should understand and support the selection criteria.

APPENDIX J

PRE-OPERATIVE PREPARATION OF THE PATIENT

BY THE REQUESTING SURGEON

The following forms are to be completed by the operating surgeon and are to accompany the patient through his/her admission process:

1) ABBREVIATED MEDICAL RECORD (SF 539). All patients will have a patient history and physical examination prior to scheduling same-day surgery. This clinical record is appropriate for all ASA Class I patients and for ASA Class II patients not receiving general anesthesia. (ASA Class II patients requiring general anesthesia must have SF 504 - Clinical Record-History-Part I; SF 505 - Clinical Record-History-Part II and III; SF 506 - Clinical Record-Physical Examination; and SF 509 - Medical Record-Progress Notes.) The results are to be recorded on this form.

2) DOCTORS ORDER SHEET (DA FORM 4256). An admission order to SDSC, requested laboratory tests, and special preoperative medications and/or instructions are to be included on this form.

3) OPERATION REQUEST AND WORKSHEET (DA FORM 4107). Requests for special preps, instruments, suture, etc. should be indicated on this form. Desired date and time of surgery should be included.

4) REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES (SF 522). A brief description of the surgery to be performed should be written in terms the patient understands. This form is to be signed by the physician performing the procedure indicating that the patient has been appropriately counseled. The patient should sign the permit and have it witnessed at this time.

5) ANESTHESIA CLINICAL RECORD (SF 517). After required entries have been made by the attending physician this form will be completed by anesthesia personnel.

All patients are required to have a CBC, differential, and urinalysis not more than seven days prior to surgery. Serology tests are required for all persons 14 years of age or older.

Chest x-rays for all personnel receiving general anesthesia or regional anesthesia must be obtained not more than 30 days prior to surgery.

An electrocardiogram taken within 30 days prior to surgery is required for all patients over 40 years of age.

APPENDIX K

PATIENT ADMINISTRATION DIVISION PREADMISSION PROCEDURES FOR THE SAME-DAY SURGERY CLINIC

1. Sources and Responsibilities for Pre-admissions:

a. The Same-Day Surgery Clinic will insure that all required admission documents are completed before sending a patient for pre-admission.

b. The requesting surgeon notifies PAD of the need for pre-admission by completing all documents directed by the procedure "Preoperative Preparation of the Patient".

2. Pre-admission Suspense File: This file will contain documentation on all pre-admitted patients and will be maintained in projected admission date sequence and alphabetically within each date.

3. A&D Pre-admission Processing: Upon notification of a pre-admission A&D will accomplish the following:

a. Interview the patient to collect data for completing the Admission and Coding Information sheet;

b. Produce admission documents as required, assign a register number, and prepare a wrist identification band;

c. Prepare the Inpatient Recording Card and send the patient with the pre-admission paperwork to the Same-Day Surgery Clinic; and

d. Prepare pre-admission transaction cards for future use as required.

4. Admission Processing for Pre-admitted Patients:

a. The A&D clerk will remove all pre-admission paperwork from the patient's file and prepare admission documents as needed. These documents will be given to the patient to handcarry to the Same-Day Surgery Clinic.

b. The A&D clerk will verify patient identification and place the ID band on the patient's wrist.

5. Cancelled/Rescheduled Pre-admissions: The following actions are required:

a. The admitting physician is responsible for notifying A&D of a cancelled pre-admission.

b. If a pre-admission is cancelled the A&D clerk will pull the patient's folder, forward the health care documentation for inclusion in the patient's outpatient medical record, delete the pre-admission record from administrative files, and perform other notifications as required.

c. If the pre-admission is rescheduled the patient's folder will be moved to a new suspense file and the transaction cards updated.

APPENDIX L

HANDLING OF NARCOTICS FOR THE SAME-DAY SURGERY CLINIC

1. All controlled substances will be signed out in the Narcotic Register.

2. Unused narcotics will be returned to the locked cabinet.

3. Controlled substances will not be left out on tables overnight, nor will they be left inside unlocked tables or cabinets.

4. Narcotics will be stored under double lock and key at all times.

5. Narcotics will be checked daily during routine operative schedules.

6. Narcotic keys will be kept in the main OR narcotic box when they are not signed out to the Same-Day Surgery Clinic.

7. If for any reason the SDSC cannot be secured during non-duty hours, the narcotics will be secured in the main operating room. They will be brought to the SDSC each morning by the anesthetist assigned to the clinic and will be returned to the main operating room at the end of the working day.

APPENDIX M

ANESTHESIA SERVICES AND PRE-MEDICATION POLICY

FOR THE SAME DAY SURGERY CLINIC (SDSC)

1. The anesthetist is responsible for insuring that the pre-operative studies are complete and the results reviewed.

2. Anesthesia is responsible for insuring adequate post-operative care and recovery.

3. Only ASA Class I and Class II patients will be treated in the SDSC.

4. Anesthetic techniques available in the SDSC include general anesthesia, regional anesthesia, IV sedation, and local anesthesia.

5. Spinal anesthesia is not considered appropriate for use in the SDSC.

6. Patients meeting discharge criteria may be sent home by anesthesia if the surgeon writes a discharge note stating "Discharged when cleared by anesthesia".

7. Anesthesia service has sole responsibility for determining the need for pre-medication. In general the use of pre-medication for patients in the SDSC is highly discouraged.

8. If a patient is taking a prescribed medication, the anesthesiologist will make a determination on whether to continue the medication as part of the patient's anesthetic management.

APPENDIX N

DISCHARGE GUIDELINES FOR THE SAME-DAY SURGERY CLINIC

1. Since all patients who go through the Same-Day Surgery Clinic are admitted, they must be discharged from the unit before they can go home.

2. The following criteria must be met before the patient will be considered eligible for discharge:

a. An uncomplicated anesthetic and an uncomplicated recovery room stay;

b. Ability to tolerate fluids by mouth;

c. Ability to ambulate without assistance;

d. Complete orientation to time, person, and place;

e. Unassisted, i.e., voluntary voiding post anesthesia;

f. Presence of a responsible adult to escort the patient home; and

g. The lack of any post-operative complications.

3. All patients who are discharged from the SDSC will be transported to the hospital lobby in a wheelchair. There they will be assisted into their vehicles to be transported home. Under no circumstances will a patient be discharged on the day of surgery unless a responsible adult is available to accompany the patient home.

4. If a patient's condition warrants further observation the patient will be transferred on a doctor's order to an appropriate inpatient unit.

5. Discharge from the SDSC requires the written order of the surgeon on the Doctors Order Sheet (DA Form 4256).

6. Prior to discharge the patient will be given:

a. Written postoperative instructions;

b. Prescriptions for any medications ordered by the surgeon;

c. Followup appointment if indicated;

d. Postoperative instructions written by the surgeon, and;

e. A list of phone numbers to call should any questions arise or an emergency develop postoperatively.

APPENDIX O

INPATIENT SURGICAL PROCEDURES QUALIFYING FOR SAME-DAY SURGERY

FEBRUARY - MARCH 1984

Service	Procedures	Total	MCCUs Obtained
General Surgery	Repair Inguinal Hernia	32	579
	Repair Umbilical Hernia	2	24
	Breast Biopsy	12	179
	Lymph Node Biopsy	1	13
	Hemorrhoidectomy	3	42
	Circumcision	6	85
	Excision Mass/Lipoma	4	58
	Sphincterotomy	1	16
	Removal Sigmoid Polyps	1	13
	Vein Ligation/Stripping	2	29
	Rectal Biopsy	1	17
	Excisional Biopsy	2	26
	Groin Exploration	1	32
Gyn	D&C	7	95
	Diagnostic Laparoscopy	7	99
	Cone Biopsy	2	26
	Tubal Ligation (laparoscopic)	7	90
	Tubal Ligation (minilap)	3	39
Urology	Circumcision	7	92
	Cystoscopy	8	103
	Epididymectomy	2	31
	Meatotomy	2	24
	Orchiectomy	1	19
	Ligation Spermatic Vein	1	16
Orthopedics	Arthroscopy	1	30
	Resection MTP Head	1	14
	Removal Ganglion Cyst	2	44
	Release Scar	1	19
	Carpal Tunnel Release	1	13
	Removal Screw	1	13
	Pinning Ring Finger	1	14
Oral Surgery	Removal Impacted Teeth	1	18
Podiatry	Excision, Exostosis	3	38
Ophthalmology	Recess Ocular Muscle	5	64
	Nasal Lacrimal Duct Probe	1	12
ENT	Myringotomy	3	38
		136	2,064

APPENDIX P

OUTPATIENT WORKLOAD QUALIFYING FOR SAME-DAY SURGERY

FEBRUARY - MARCH 1984

CLINIC	PROCEDURES	TOTAL	MCCUs (Total x .3)
Dental	Tooth Removal, Complicated	144	43.2
	Tooth Removal, Impacted	164	49.2
	Alveoloplasty with Extraction	89	26.7
	Removal of Exotosis	2	0.6
	Biopsy	9	2.7
	Maxillary Sinusotomy	2	0.6
Dermatology	Excisional Biopsy	23	6.9
ENT	Myringotomy	3	0.9
	Repair, Nasal Fracture	3	0.9
Medical	Endoscopy	14	4.2
	Colonoscopy	1	0.3
	Rectal Dilatation	2	0.6
OB-GYN	Culdocentesis	2	0.6
	Cervical Biopsy	3	0.9
	Excisional of Polyps, Cysts	1	0.3
	Hysterosalpingogram	5	1.5
Orthopedic/Podiatry	Pin Removal	1	0.3
	Closed Reductions	4	1.2
	Toenail Removal	23	6.9
	Ganglion Cyst	4	1.2
Surgery	Removal of Lipoma/Mass	36	10.8
	Breast Biopsy	12	3.6
	Vasectomy	4	1.2
Urology	Retrograde Pyelograms	8	2.4
	Vasectomy	12	3.6
	Circumcision	3	0.9
	Prostrate Biopsy	3	0.9
Total Credit for Outpatient Surgery		577	173.1

Total MCCUs if these procedures had been performed in a same-day surgery program (total number x 11) = 6,347

MCCUs lost by doing these procedures in the clinic for outpatient weighted value = total potential minus actual MCCU credit obtained = 6,347 - 173.1 or about 6,174.

*Ophthalmology identified 19 procedures such as blepharoplasty, cysts and nevus removal, lacrimal probes, and pterygium removal for this two month period (209 potential MCCUs).

**Non-stress tests performed in labor and delivery areas on outpatients could add 70 procedures to these totals and add 770 MCCUs.

APPENDIX Q

MARKETING PLAN

I. ASSUMPTIONS

A. Additional staffing for the Same-Day Surgery Clinic may not be available.

B. There is staff bias and/or reluctance to implement a program which adds to their administrative requirements.

C. Physicians may be reluctant to subject patients to the payment of a surcharge for procedures performed in a same-day surgery clinic when these procedures have been performed in outpatient clinics for a period of time.

II. GOALS AND OBJECTIVES

A. Primary Goal: To gain staff support for implementing same-day surgery at this hospital.

B. Secondary Goals:

1. To increase staff awareness of the same-day surgery concept.

2. To educate the staff about patients currently treated as outpatients who qualify for same-day surgery.

3. To increase staff awareness of the impact of same-day surgery on MCCUs.

4. To increase the effective utilization of a same-day surgery clinic.

5. To educate the staff about the advantages of same-day surgery, especially for patients.

6. To demonstrate to the staff that same-day surgery can be implemented even with current staffing.

7. To educate staff on the minimum paperwork requirements for same-day surgery considering the workload credit.

8. To increase potential patients' awareness of the same-day surgery concept as it applies to military facilities.

III. PLAN OF ACTION

A. Education

	Task	Responsible Individual
1.	Interview the Chief of each service to determine specific needs or concerns.	SDSC Coordinator

	Task	Responsible Individual
2.	Publish a list of suitable procedures for the SDSC and solicit additional input from clinic personnel.	SDSC Coordinator
3.	Discuss the results of the two month survey with clinic personnel and the impact it has on their clinic in terms of MCCUs.	SDSC Coordinator
4.	Discuss required clinical records with the chief of each service, head nurse of each clinic, and NCOIC of each clinic.	Medical Records Administrator
5.	Discuss advantages of same-day surgery and how the service can operate at this facility at the Health Consumer Committee and with members of the retired officers' association.	MEDDAC Commander
6.	Provide copies of proposed SDSC policies and procedures to each service which will be affected and solicit further input.	SDSC Coordinator
7.	Discuss a limited implementation of same-day surgery in the present facility. Coordinate responses with Chief, Department of Surgery, Chief, Anesthesia and Operative Service, and Head Nurse of the Operating Room.	SDSC Coordinator
8.	Publish articles in the post newspaper to familiarize potential patients with same-day surgery once a decision is made to implement a SDSC.	Public Affairs Office/ SDSC Coordinator
B.	Followup	
1.	Revise SDSC plan using input provided and redistribute information with changes.	SDSC Coordinator
2.	Re-evaluate and revise overall marketing plan.	SDSC Coordinator

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